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No. 08-543

Supreme Court, U.S.
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IN THE
Supreme Court of the United States

LAWRENCE R. POLINER, M.D., and
LAWRENCE R. POLINER, M.D., P.A.,

Petitioners,

v.

TEXAS HEALTH SYSTEM, doing business as PRESBYTERIAN HOSPITAL OF DALLAS, TEXAS, a Texas non-profit corporation, and JAMES KNOCHEL, M.D.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF *AMICUS CURIAE* ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC. IN SUPPORT OF PETITIONERS

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QUESTIONS PRESENTED

The Healthcare Quality Improvement Act of 1986, §402 *et seq.*, 42 U.S.C. §§ 11101 *et seq.* (2000) ("HCQIA") establishes limited immunity from money damages for professional review actions taken (1) in the reasonable belief that the action was in furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3). A professional review action is presumed to have met these standards unless rebutted by a preponderance of the evidence. 42 U.S.C. § 11112(a) (2002).

The questions presented are:

1. Can a court exclude all evidence of subjective motives (an entire category of evidence) when it considers whether a defendant possessed a "reasonable belief" as required for HCQIA immunity under subsection (1) and (4), when such exclusion effectively:

a) Usurps the fact-finding role of the jury?

b) Renders state peer review immunity statutes meaningless?

c) Transforms the qualified immunity intended by Congress into absolute immunity?

2. What are the categories of evidence that can be considered in a court's determination of whether plaintiff's evidence is sufficient to rebut the statutory presumption?

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INTEREST OF *AMICUS CURIAE*[1]

The Association of American Physicians and Surgeons, Inc. ("AAPS"), founded in 1943, is a non-profit, national group of thousands of physicians.

[1] This brief is filed with the written consent of all parties, with timely notice provided in compliance with Rule 37.2(a) of the Supreme Court of the United States. Pursuant to its Rule 37.6, counsel for *amicus curiae* authored this brief in whole, and no counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *amicus*, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

AAPS has members who have suffered from bad faith peer review by hospitals, also known as "sham peer review," as retaliation for practicing innovative medicine or standing up for patients. In many cases the sham peer reviews are initiated because a talented physician posed a competitive threat to colleagues who are influential at the hospital.

AAPS is dedicated to defending the practice of private and ethical medicine so that physicians may best serve their patients without interference by third parties. AAPS has filed *amicus curiae* briefs in numerous cases before the United States Supreme Court and federal Courts of Appeals, and its submissions have been cited in opinions. Submissions by AAPS have been cited by Justices on this Court. *See, e.g., District of Columbia v. Heller*, 128 S. Ct. 2783, 2860 (2008) (Breyer, Stevens, Souter and Ginsburg, JJ., dissenting); *Stenberg v. Carhart*, 530 U.S. 914, 933 (2000).

The issues presented in this case are of national importance, affecting virtually every hospital in the nation, every physician at those hospitals, and every one of their patients. *Amicus* has a direct and vital interest in these issues presented based on the harmful effect on the practice of medicine and the quality of patient care that results from judicially created – and statutorily unjustified – immunity for bad faith peer review.

SUMMARY OF ARGUMENT

The decision below is the latest – and most sweeping – of lower court rulings that increasingly misinterpret the federal statute governing hospital peer review known as The Healthcare Quality Improve-

ment Act of 1986, §402 *et seq.*, 42 U.S.C. §§ 11101 *et seq.* (2000) ("HCQIA"). These decisions, and particularly the Fifth Circuit opinion below, substitute their (untrained) medical judgment and write the "reasonable belief" requirement of HCQIA out of the statute entirely. Review by this Court is essential to restore the plain meaning of "reasonable belief" to the federal statute.

The Fifth Circuit below opined at length about its own medical view of five cases handled by cardiologist Petitioner Lawrence Poliner, M.D., in reliance on the bad faith selection and presentation of these cases. In fact, there was nothing improper about Petitioner's care in any of these five cases, and the mischaracterization of medical cases is precisely what HCQIA prohibits. Respondents themselves had no genuine concern about these cases, as confirmed by the findings of the trial court based on exhaustive testimony. HCQIA requires a genuine concern or "reasonable belief" before smearing a physician, in order to prevent precisely the miscarriage of justice that occurred here. Dr. Poliner was absolved by the hospital of anything improper in these cases, and HCQIA precludes trumping up spurious charges to gain a competitive advantage. This Petition starkly illustrates the growing misapplication of HCQIA, and presents the best opportunity for this Court to correct it.

The Fifth Circuit ruled that evidence of malice and bad faith should be excluded from legal challenges to peer review, while simultaneously relying on the five medical cases selected and presented through malice and bad faith. Obviously cases selected and analyzed through bad faith are not credible evidence of the skills of a physician. It is illogical

to exclude overwhelming evidence of bad faith and then insist on drawing conclusions from the product of that same bad faith. HCQIA expressly prohibits this unjustified approach, yet that is what the Fifth Circuit opinion and Respondents use as a legal standard.

In fact, evidence of malice and bad faith is a central element of the standard set by HCQIA, and immunity properly attaches to a peer review committee only if it acts in a "reasonable belief" of furthering quality patient care. *See* HCQIA, 42 U.S.C. § 11112(a)(1). The phrase "reasonable belief" in the statute could not be clearer. The "belief" in improving health care must exist - as opposed to bad faith - and it must be "reasonable". Immunity exists only if there is (i) a belief that patient care is being improved and (ii) such belief is reasonable. Immunity must not attach if either element is lacking. This statutory immunity is more than adequate for revoking the privileges of negligent physicians, and federal law does not support the *wrongful* destruction of a physician's career under the guise of peer review.

The precedent below, in giving hospitals nationwide a blank check to engage in malicious conduct, is untenable. The casualty is our nation's medical system and its ability to protect life, foster innovation, and benefit from competition. Physicians cannot innovate or speak out for patient care when it could cost them their career at the hands of a judicially protected bad faith peer review. Numerous articles, lawsuits and injustices including the case at bar are compelling illustrations of how hospitals exploit their immunity for sham peer review to intimidate or eliminate good physicians.

In this case the trial court found overwhelming evidence of bad faith in pressing a half-dozen cases against Petitioner, and the Fifth Circuit found no basis for overruling that central factual finding. Instead, the appellate decision simply excluded it and treated the cases as though they had been selected and analyzed in good faith:

> That Poliner had over 20 years of experience and an apparently clean record before these cases only serves to heighten the concern: why was this experienced physician now having these problems?

Poliner v. Texas Health Sys., 537 F.3d 368, 379 (5th Cir. 2008). But, as established by the trial court, there were no genuine "problems" or "concern", and the parading of these cases was a charade lacking in medical significance. HCQIA expressly forbids treating a bad faith peer review as though it were done in good faith, and then immunizing the harm done by it.

A grant of this Petition for Certiorari is essential to correct this error in statutory interpretation, which continues to spread at the expense of the integrity and quality of medical care.

ARGUMENT

An error in statutory interpretation in a split decision over a decade ago by the Ninth Circuit has gone uncorrected and spread for more than 15 years, causing expansive use of an incorrect judicial standard of absolute immunity for bad faith peer review by hospitals. Physicians who defend life, advance innovation, or stand up for patients, are intimidated, threatened, and often destroyed by self-serving wrongdoing by administrators, competitors, and adversaries. This is an epidemic of intimidating our

finest and most ethical physicians, and restraining much-needed advances in medical care.

The root of this epidemic is a 2-1 decision by the Court of Appeals for the Ninth Circuit that downplayed the essential "belief" aspect of the "subjective belief" requirement. *Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992). There was no petition for certiorari pursued to reverse that decision, and it has since been reflexively repeated and expanded by lower courts. In this case the Fifth Circuit amplified this error by overturning a jury verdict where there was proven wrongdoing by defendants, and then entering judgment for the defendants without even granting a new trial. The result, if left unreviewed by this Court, is that hospitals will expect to receive immunity for wrongful, anti-competitive, and retaliatory peer reviews.

This precedent is catastrophic for medical care nationwide. Physicians are deterred from speaking out against hospital officials and competitors connected with the hospital. "Sham peer review" has become a powerful deterrent to improving quality of care. The interpretation that HCQIA immunity extends to improper motives is as harmful as it is legally unjustified. The courts below have converted the "reasonable belief" required by the statute into an "unreasonable rationalization that might be believed by others later." Legal immunity is thereby used to encourage improper motives and bad faith.

As the first Justice Harlan wrote for a unanimous Supreme Court over a century ago, where the statutory "language used is so plain and unambiguous," "a refusal to recognize its natural, obvious meaning would be justly regarded as indicating a purpose to change the law by judicial action based upon some

supposed policy of Congress." *Bate Refrigerating Co. v. Sulzberger*, 157 U.S. 1, 36-37 (1895). Here the statutory language of HCQIA in requiring a "reasonable belief" is "so plain and unambiguous" as to require adherence to its textual meaning. Where, as here, the terms of the statute are clear, such terms should not be altered based on speculation about legislative intent.

I. THE FIFTH CIRCUIT'S RELIANCE ON ITS OWN (UNTRAINED) VIEW OF UNREPRESENTATIVE MEDICAL CASES, WHICH WERE PROVEN TO BE THE PRODUCT OF BAD FAITH, IS PRECISELY WHAT HCQIA PROHIBITS.

The five cases at the heart of the Fifth Circuit's decision below are medically insignificant and the proven result of bad faith in their selection, analysis and presentation. Their contrived nature is typical of bad faith peer reviews. Every cardiologist in the nation has inevitable complications in patients; every busy professional has less than a 100% success rate, particularly when failures of associates are included. HCQIA expressly forbids attaching immunity to a bad faith review, which inherently distorts the selection, analysis and presentation of a professional's work. The finest physician in the world could see his reputation and his career ruined if a bad faith reviewer were permitted with impunity to pick non-representative cases and present them in a malicious and distorted manner. Such "evidence" is thoroughly corrupted, and federal law denies immunity to those who attempt it. HCQIA does not condone the repeated smearing of a good physician – smearing that will likely continue with Respondents' filing with this

Court — based on cases of exaggerated significance that were selected in bad faith, as found by the jury below. (App. 132a-134a).

Yet AAPS has seen the same malicious tactic repeated again and again, and undoubtedly Respondents will use it here: rely on a few exaggerated and distorted cases *not* representative of the physician's practice, where fault lay elsewhere, and through bad faith smear the targeted physician. HCQIA prohibits this with its express requirement of a "reasonable belief" in furtherance of quality health care, as discussed in Point II below.

The five cases underlying the decision below illustrate how bad faith should never be protected with immunity. 537 F.3d at 370-71. These cases were frivolous at best, and were not selected and presented in an objective or good faith manner. A look at each case illustrates the contrivance.

The first case cited below (Patient 36) was a failure in the hospital's own equipment that prevented a perfect initial diagnosis, and the deceitful peer review shifted blame unjustifiably to Petitioner. The Fifth Circuit below had no justification for relying on its own (untrained) medical opinion about it as the basis for its decision. Without citation or basis in the record, the appellate court below blamed Petitioner for making a "diagnostic mistake." *Id.* at 370. Had this case been presented in good faith, the role of the faulty hospital equipment in causing this harmless error would have been clear. (App. 193a-194a, which cites to the record.) Regardless, Petitioner's care of the patient in this case was entirely proper, and the decision below does not state otherwise. *Id.* at 370-71. Giving such prominence to a case in which the

care was entirely appropriate illustrates the inherent problem with relying on cases submitted in bad faith.

The four other cases trumpeted by Respondents, and at the foundation of the decision below, are even less significant. Patient 10 developed a mere rash after a procedure. The bad faith peer reviewers, and the appellate court, ascribed significance to this rash. *Id.* at 371 & n.7. In fact, the patient had exercised her right to refuse pre-treatment so as to prevent the rash. Petitioner did nothing wrong. The appellate court recognized this, and realized that the jury found bad faith by the reviewers in selecting and presenting these cases, App. 132a-134a, yet included the bad faith allegations as a basis for its judgment in favor of the hospital defendants. This is precisely what HCQIA prohibits by requiring proof of a "reasonable belief" in furtherance of quality care as a condition of ruling in favor of the peer reviewers.

Just as no statistician would take seriously a non-representative data sample, no court should apply HCQIA to cases that are the product of proven bad faith. Bad faith can easily mislead a court into thinking it is viewing something medically significant, when in fact it is nonsensical. The occurrence of a rash in a patient after a life-saving procedure performed by a cardiologist is not something to justify destroying his reputation, particularly when he had no fault for it.

The other patients' cases are likewise medically insignificant, yet the appellate court attached significance to them due to being misled by the bad faith behind the peer review. Patient 3 concerned Petitioner's reuse of a sheath site, a routine medical practice that was entirely justified. (App. 192a, which cites to the record.) No harm resulted to the patient,

who was discharged in good condition, though this is omitted from the decision below. *Id.* at 371 & n.5. A common tactic in sham peer review is to present cases in which, unrealized by other reviewers and courts, the patient actually did perfectly well and there was no harm or risk of harm. The bad faith criticism is nothing more than biased speculation that is even disproven by the evidence.

Most sham peer reviews look for a patient who died and include that case, because its significance can be easily exaggerated to a layman. Virtually all cardiologists have patients who die, just as virtually all good trial lawyers have lost some cases. Patient 18 fit the bill here. She was 88 years old and went into cardiogenic shock *before* Petitioner's catheterization. A hospital committee performed its customary review and found that Petitioner's care was entirely appropriate, yet this was trumped up later for the bad faith peer review and repeated by the decision below. *Id.* at 371 & n.8; App. 189a-190a (which cites to the record).

Patient 9 was an elderly, hypertensive patient who had a stroke after Petitioner's procedure. No fault could be found with Petitioner's operation and, as recognized by the decision below, there was nothing Petitioner could have done to prevent the stroke; any mistakes were made by the nursing staff, not Petitioner. *Id.* at 371 & n.6.

Courts should not be misled by the distortions and omissions inherent in bad faith peer review, and this Court should clarify that HCQIA does not support the judiciary passing medical judgment on cases that are selected, analyzed, and presented in bad faith—or basically accepting the judgment asserted by the sham peer review without review or question. Res-

pondents should not continue here to distort these cases, which were plainly selected and presented for the purpose of smearing Petitioner rather than advancing quality health care as mandated by HCQIA. Analyzing medical cases presented in bad faith is a fool's errand, and rubber stamping the corrupt prior review is worse. The proof of bad faith by the trial court below precludes the case-by-case inquiry at the core of Respondents' arguments and the appellate decision.

This Court should grant review here to end the judicial second-guessing of medical cases that are presented in bad faith as though they are significant, when in fact they are not. A harmless rash, an unpreventable death, inadequate hospital diagnostic equipment, and nursing staff errors should not be the basis for sweeping judgments in favor of the perpetrators of sham peer reviews against innovative and productive physicians. It thwarts the progress of medicine and contravenes the text of HCQIA to allow such bad faith to make a mockery of good medical practice.

In sum, the five cases at the heart of the decision below were plainly contrived: most consisted of patients who performed well, and included inevitable complications (like a rash) that were no fault of the targeted physician. Two of the cases, the elderly death and the supposedly incorrect diagnosis about an artery, are typical of sham peer review in inflaming a stronger reaction by a reviewer (including a court) than is warranted. Completely missing from these cases is any evidence that they were representative of the physician's overall practice. They were not. Yet these cases will undoubtedly be paraded by Respondents again before this Court in the hope of

eliciting a layman's reaction, which is what a proper application of HCQIA would prevent.

II. HCQIA'S REQUIREMENT OF A "REASONABLE BELIEF" IN FURTHERING QUALITY HEALTH CARE DOES NOT REQUIRE EXCLUSION OF ALL EVIDENCE OF BAD FAITH.

The terms of HCQIA are clear: a reasonable "*belief*" that the peer review advances the quality of medicine is required before immunity can apply. 42 U.S.C. § 11112(a)(1) (emphasis added). This clear text of a statute trumps any speculation about legislative intent. "Judges interpret laws rather than reconstruct legislators' intentions. Where the language of those laws is clear, we are not free to replace it with an unenacted legislative intent." *INS v. Cardoza-Fonseca*, 480 U.S. 421, 452-53 (1987) (Scalia, J., concurring). *See also Unexcelled Chemical Corp.* v. *United States*, 345 U.S. 59, 64 (1953) (opinion of Douglas, J.); *United States* v. *Sullivan*, 332 U.S. 689, 693 (1948) (opinion of Black, J.); *Packard Motor Car Co.* v. *NLRB*, 330 U.S. 485, 492 (1947) (opinion of Jackson, J.) ("We are invited to make a lengthy examination of views expressed in Congress while this and later legislation was pending .... There is, however, no ambiguity in this Act to be clarified by resort to legislative history, either of the Act itself or of subsequent legislative proposals ....").

As demonstrated below, it was a reversible error for the court below to exclude an entire category of evidence about "belief" from this case. *See* 537 F.3d at 379-80.

A. The Plain Meaning of HCQIA Requires Subjective Belief as a Condition of Immunity.

The statutory term "reasonable belief" is not the same as "reasonable basis" or "improper belief but a proper result." Rather, the term "reasonable belief" must mean, first and foremost, a "belief" underlying the action. There is no justification for courts to look beyond this plain meaning and probe legislative history to alter it. After all, there is no legislative history for all the hundreds of Congressmen, many dozens of Senators, and President Ronald Reagan as to what they intended in enacting or signing this legislation. They would have probably pointed to the text itself, as courts should do.

Yet courts, most notably the lower court here and *Austin v. McNamara*, *supra*, failed to apply the text of "reasonable belief." The lower court incorrectly held that "bad faith is immaterial." *Id.* at 380 (quoting, *inter alia*, *Austin*). These precedents, grounded in the initial error of *Austin*, have read the "belief" aspect of the phrase entirely out of the law, and replaced it with a purely objective test to the exclusion of all evidence of the motivating belief. As fully described in the Petition, the jury found malicious intent and pervasive wrongdoing, App. 132a-134a, and the appellate court's own review of the medical records hardly justifies its statement that there were "legitimate concerns." *Id.* at 384. The concerns were *not* legitimate, and HCQIA does not provide immunity for illegitimate peer review.

Judge Pregerson was correct in dissenting from the *Austin* decision when he declared, "Evidence of motive and intent is relevant to show whether the defendants possessed a reasonable belief that [an ad-

verse professional review action] was warranted by the facts known." 979 F.2d at 741 n.3 (Pregerson, J., dissenting). But other circuits, relying on the *Austin* majority, repeated its error. *See, e.g., Bryan v. James E. Holmes Reg. Med. Ctr.*, 33 F.3d 1318, 1335 (11th Cir. 1994), *cert. denied*, 514 U.S. 1019 (1995) ("The test is an objective one, so bad faith is immaterial."); *see also Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 32 (1st Cir. 2002) (collecting cases); *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 914 (8th Cir. 1999), *cert. denied*, 528 U.S. 1137 (2000) ("In the HCQIA immunity context, the circuits that have considered the issue all agree that the subjective bias or bad faith motives of the peer reviewers is irrelevant."). The decision below extends these erroneous precedents even further by overturning a jury finding of wrongdoing.

The Petition presents a manifest injustice resulting from allowing speculation about legislative intent to trump the statutory text itself. The Petition should be granted to enforce the text of HCQIA as it was written. *See generally* John F. Manning, "What Divides Textualists from Purposivists?," 106 Colum. L. Rev. 70 (2006); Caleb Nelson, "What Is Textualism?," 91 Va. L. Rev. 347, 349 (2005).

B. HCQIA's Legislative History Does Not Support Excluding and Ignoring Subjective Belief in Connection with Immunity.

The court below relied on precedents based on a misreading of the legislative history that began in *Austin v. McNamara*, where the split Ninth Circuit decision misconstrued the House Committee's desire for a "more objective" test as meaning an "only objec-

tive" test. "Our sister circuits have roundly rejected the argument that such subjective motivations overcome HCQIA immunity, as do we." *Poliner*, 537 F.3d at 379-80 (citing *Austin*). But the Fifth Circuit's exclusion of an entire category of evidence concerning intent and bad faith, no matter how egregious, rests on an erroneous interpretation of statutory history set forth in *Austin*:

> Initially, the [House] Committee considered a 'good faith' standard for professional review actions. In response to concerns that 'good faith' might be misinterpreted as requiring **only** a test of the subjective state of mind of the physicians conducting the professional review action, the Committee changed to a **more objective** 'reasonable belief' standard. The Committee intends that this test will be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their actions would restrict incompetent behavior or would protect patients.

979 F.2d at 734 (citing H.R. Rep. No. 903, 99th Cong., 2d Sess. 10, *reprinted in* 1986 Code Cong. & Admin. News 6392-93, emphasis altered). The *Austin* court failed to recognize that the Committee was merely rejecting an "only subjective" test, rather than eliminating any and all inquiries into subjective belief; the *Austin* court thereby created an incorrect "only objective" test that is increasingly exploited by sham peer review.

There is no need to consult the legislative history here, because the statutory text itself is clear. Moreover, the above legislative history does not support ignoring the subjective belief underlying the peer review. One commentator spotted the obvious flaw in

the judicial elimination of a subjective test based on the legislative history:

> The legislative history of the HCQIA does not support this interpretation of the Act. Congress initially considered a good faith test; however, it was concerned that such a test would be "misinterpreted by courts as requiring only a test of the subjective state of mind" of the peer review committee members. Therefore, Congress adopted the "more objective 'reasonable belief standard."

Anthony W. Rodgers, "Comment: Procedural Protections During Medical Peer Review: A Reinterpretation of the Health Care Quality Improvement Act of 1986," 111 Penn St. L. Rev. 1047, 1056 (Spring 2007) (citations omitted). The *Austin* Court overlooked how Congress intended that HCQIA encourage "good faith professional review activities of health care entities."

The reliance on legislative intent also omits what is strikingly absent from the legislative history: any indication that Congress sought to tilt the playing field in favor of unrestrained and unaccountable abuse of power by hospitals in eliminating innovative, competitive or outspoken physicians. Nothing in the legislative history even remotely supports the view that HCQIA could be applied to protect sham peer review, and it was reversible error for the Fifth Circuit to allow such use. Yet that is what has occurred by excluding all evidence of bad faith from judicial review of peer review actions.

Ignoring subjective belief is plainly contrary to the stated goal of the HCQIA: to advance the quality of medical care. Legitimate peer review is to improve patient care, not to advance improper motives of self-interest at a hospital. HCQIA requires "reasonable

belief," and any "objective test" based on that standard must still require a legitimate belief. The appellate decision itself references the term "concern" nearly two dozen times, implying the necessity of a legitimate concern to justify hospital action. *See, e.g.*, 537 F.3d at 384 (citing "legitimate concerns" despite the finding of bad faith). But the jury found a lack of a legitimate concern, and the appellate court extended immunity to cover all bad faith in peer review. (App. 132a-134a.) This contravenes HCQIA.

C. "Reasonable Belief" Must Include a Subjective Element to Avoid Constitutional Difficulties.

In the absence of a subjective test, immunity has been applied to protect even discriminatory conduct during peer reviews. For example, a Maryland Court relied on *Austin* to hold that sexual discrimination by peer reviewers "which would be considered illegal in the context of employment [is] irrelevant when challenging a medical peer review process." *Bender v. Suburban Hosp.*, Inc., 758 A.2d 1090, 1100 (Md. Ct. Spec. App. 2000), *cert. denied*, 362 Md. 34, 762 A.2d 968 (2000). But a statutory grant of immunity to protect a discriminatory purpose would raise grave constitutional difficulties, and such interpretation of HCQIA to immunize discrimination should be avoided.

"It has long been an axiom of statutory interpretation that 'where an otherwise acceptable construction of a statute would raise serious constitutional problems, the Court will construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress.'" *Public Citizen v. United States Dep't of Justice*, 491 U.S. 440, 466

(1989) (citing *Edward J. DeBartolo Corp.* v. *Florida Gulf Coast Building & Construction Trades Council*, 485 U.S. 568, 575 (1988)). Sutherland's Statutes and Statutory Construction recites that a "court should construe legislative enactments to avoid constitutional difficulties if possible" and that "when possible, statutory provisions should be construed in such a way as to avoid unconstitutionality." Norman Singer, Sutherland's Statutes and Statutory Construction 45.11, 48-49 n.4 & n.7 (5th ed. 1992).

Construing HCQIA to immunize bad faith, and even discriminatory intent, triggers constitutional issues of due process and equal protection. Such an interpretation should be rejected under the doctrine of constitutional avoidance.

III. EXTENDING IMMUNITY TO IMPROPER MOTIVES IN PEER REVIEW IS HAVING A CATASTROPHIC EFFECT ON THE PUBLIC INTEREST.

The judicially created federal immunity for bad faith in peer review has unleashed a national epidemic of sham peer review, at the expense of the public interest. *See, e.g.*, Gail Weiss, "Is Peer Review Worth Saving?", *Medical Economics* (Feb. 18, 2005);[2] Steve Twedt, "The Cost of Courage: How the Tables Turn on Doctors," *Pittsburgh Post-Gazette* A1 (Oct. 26, 2003);[3] John Zicconi, "Due Process or Professional Assassination?", *Unique Opportunities* (March/April

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[2] http://www.memag.com/memag/article/articleDetail.jsp?id=147405 (viewed 11/20/08).

[3] http://www.post-gazette.com/pg/03299/234499.stm (viewed 11/20/08).

2001);[4] David Townsend, "Hospital Peer Review Is a Kangaroo Court," *Medical Economics* 133 (Feb. 7, 2000). Patients and the public suffer the most from the removal of competent and skilled physicians from the market, or their being deterred from competing.

For years the catastrophic nature of sham peer review has been recounted in medical journals. *See, e.g.*, William Summers, "Sham Peer Review: A Psychiatrist's Experience and Analysis," 10 *Journal of American Physicians and Surgeons* 125 (Winter 2005);[5] Roland Chalifoux, Jr., M.D., "So What Is a Sham Peer Review?", 7 *Medscape General Medicine* (No. 4) 47 (2005); John Minarcik, M.D., "Sham Peer Review: a Pathology Report," 9 *Journal of American Physicians and Surgeons* 121 (Winter 2004);[6] Lawrence Huntoon, M.D., Ph.D., "Sham Peer Review: The Unjust Objective Test," 12 *Journal of American Physicians and Surgeons* 100 (Winter 2004);[7] William Parmley, "Clinical Peer Review or Competitive Hatchet Job," 36 *Journal of the American College of Cardiology* 2347 (2000).

Hospitals and their favorite physicians are motivated by money just like everyone else, and if they enjoy immunity to eliminate competitors who impinge on their income, then they will do precisely that. *See, e.g.*, Jeff Chu, "Doctors Who Hurt Doctors," *Time* 52 (Aug. 15, 2005) ("Th[e] system is too open to manipulation and needs reform, says the 4,000-member American Association [sic] of Physicians and

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[4] http://www.uoworks.com/pdfs/feats/PEERREVIEW.pdf (viewed 11/20/08).

[5] http://www.jpands.org/vol10no4/summers.pdf (viewed 11/20/08).

[6] http://www.jpands.org/vol9no4/minarcik.pdf (viewed 11/20/08).

[7] http://www.jpands.org/vol12no4/huntoon.pdf (viewed 11/20/08).

Surgeons."). Patients and the public interest suffer most when physicians are deterred by sham peer review from advancing quality medical care.

If a physician were truly a danger to patients, then the state medical board would restrict or revoke his medical license. Patients would abandon such a physician, just as shoppers will not continue buying bad products. Or if a hospital wants to rid itself of a negligent physician, then it may do so regardless of whether it has special immunity under federal law. But immunity for wrongful acts is misplaced.

Judicial construction of HCQIA to grant immunity to hospitals for bad faith peer review has caused an epidemic of abuse, now greatly magnified by the decision below.

CONCLUSION

This Court should grant the Petition for *Writ of Certiorari.*

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